

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049446

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12946

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JAN 9 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
Length of stay in 1b 9 weeks		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1		d. STREET ADDRESS (If outside, give location) 1930 Winnebago	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Fred Middle W. Last Geiger			4. DATE OF DEATH Month 12 Day 27 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married: <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/9/93	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New Memphis, Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John Geiger		13b. MOTHER'S MAIDEN NAME Lina Sahlender	
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Nellie White -- 1930 Winnebago		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>49/x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION New Memphis, Illinois.		COUNTY STATE
21. I attended the deceased from 10-25-63 to 12-27-63 and last saw her alive on 12-27-63 Death occurred at 5:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) John W. Benson, M.D.	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 12-27-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/30/63	23c. NAME OF CEMETERY OR CREMATORY New Memphis Cemetery
23d. LOCATION (City, town, or county) New Memphis, Illinois.		(State)
24. FUNERAL DIRECTOR WACKER-HELDERLE	ADDRESS 3634 Gravois	25. DATE RECD. BY LOCAL REG. DEC 30 1963
26. REGISTRAR'S SIGNATURE Lois Smith, M.D.		

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Clarence M. Billo*

Licensed Embalmer No. 4375

P. O. Address St. Louis 14, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.